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MY VISION FOR RURAL HEALTH IN THE 1990S

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NEW ORLEANS, LOUISIANA

As corrected on [illegible] Koop

I AM PLEASED TO HAVE THE OPPORTUNITY TO BE A PART OF THE NATIONAL RURAL HEALTH ASSOCIATION'S ANNUAL CONFERENCE.

I AM SORRY I WAS NOT ABLE TO ACCEPT YOUR INVITATION TO SPEAK TO THE CONFERENCE IN WASHINGTON TWO YEARS AGO. ACTUALLY I WOULD PREFER TO BE IN NEW ORLEANS.

WHEN I ACCEPTED YOUR INVITATION LAST FALL I FELT AN INTELLECTUAL BOND TO YOUR CAUSE, BUT DID NOT KNOW A LOT ABOUT IT.

SINCE THAT TIME I HAVE WALKED THE LONELY ROADS OF APPALACHIA, I HAVE VISITED SICK CHILDREN, VISITED WITH RURAL ADULTS, AND TALKED TO WORRIED AND OVERWHELMED HEALTH CARE PROVIDERS.

I HAVE SEEN THE FACE OF RURAL POVERTY, I HAVE SEEN THE GROWING LOSS OF THE CAPACITY AND LOSS OF PUBLIC CONFIDENCE IN LOCAL HEALTH CARE DELIVERY.

MY INTELLECTUAL BOND WITH YOU AND YOUR RURAL CONSTITUENCY IS NOW AN EMOTIONAL BOND, AS WELL.

I NOW FEEL AN EMOTIONAL BOND WITH YOU AND YOUR RURAL CONSTITUENCY. WHILE I AM APPALLED AT THE LEVEL OF NEED FOR ALL HUMAN SERVICES IN OUR RURAL AREAS, MY HEART IS WARMED AT THE STRENGTH, COURAGE, AND HOPE OF OUR RURAL CITIZENS.

I HAVE KNOWN WHAT NRHA DOES FOR SOME TIME. NOW I KNOW WHY IN A VERY PERSONAL WAY.

IN THE LAST YEAR NRHA HAS BLOOMED INTO MATURITY.

YOU HAVE BECOME A FORCE TO BE RECKONED WITH AS AN INTEREST GROUP PROMOTING THE HEALTH AND WELL BEING OF RURAL PEOPLE.

YOU HAVE COME A LONG WAY FROM THE LITTLE BAND OF FEDERALLY ASSISTED RURAL PROJECTS OF THE MID-1970'S.

YOU HAVE ALL THE ELEMENTS OF A MATURE ORGANIZATION. YOU HAVE FOUNDING FATHERS: DAVID FENTON, MIKE SAMUELS, JOHN CLARK, JOHN LACASE.

YOU EVEN HAVE YOUR MARTYRS: LOU GORIN, FOR WHOM YOUR HIGHEST AWARD IS NAMED, TERRY REILLY, FOR WHOM THE MEMORIAL LECTURE IS NAMED.

A VERY RICH HISTORY INDEED WITH A CLEAR TREND OF DIVERSIFICATION TO INCLUDE ALL CONCERNED GROUPS.

YOU MERGED WITH THE AMERICAN RURAL HEALTH ASSOCIATION TO ADD AN ACADEMIC AND RESEARCH COMPONENT AND THE JOURNAL OF RURAL HEALTH, TO SHARE KNOWLEDGE.

I COULD CONTINUE,

BUT THE POINT IS THAT YOU HAVE ACHIEVED A DIVERSITY THAT MIRRORS THE RURAL AMERICA FOR WHICH YOU ARE ADVOCATES.

THE COALITION YOU HAVE BUILT CUTS ACROSS MORE NARROWLY FOCUSED INSTITUTIONAL AND PROFESSIONAL INTERESTS.

MUCH OF THE CREDIT FOR YOUR SUCCESS MUST GO TO YOUR EXECUTIVE DIRECTOR BOB VAN HOOK.

WHEN HE ASSUMED HIS POSITION AS EXECUTIVE DIRECTOR THIS ORGANIZATION WAS ON THE CRITICAL LIST. HE BROUGHT YOU OUT OF THE ICU, YOU HAVE RECOVERED AND ARE POST REHABILITATION.

ON YOUR BEHALF HE HAS BUILT NRHA INTO A STABLE BROAD-BASED ORGANIZATION OF NEARLY 2000 INDIVIDUAL AND INSTITUTIONAL MEMBERS AND A WELL DIVERSIFIED BUDGET OF OVER $1.5 MILLION .

THIS STRONG COALITION OF PRIMARY CARE CENTERS, HOSPITALS, CLINICIANS, ACADEMICS, RESEARCHERS, AND COMMUNITY PEOPLE HAS SUCCESSFULLY ENGAGED THE POLITICAL PROCESS.

YOUR FRIENDS INCLUDE, AMONG OTHERS, SENATORS HARKEN, BYRD, HOLLINGS, DURENBEGER, DOLE, PRESIDENT CARTER, AND VICE PRESIDENT MONDALE.

AND AS WELL AS

YOUR ALLIES INCLUDE THE ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN ACADEMY OF NURSE PRACTITIONERS, AND THE AMERICAN HOSPITAL ASSOCIATION, AND NOW ME.

YOUR CONFERENCE THEME "EMPOWERED TO MAKE A DIFFERENCE " REFLECTS THE CAPACITY YOU AS THE NATIONAL RURAL HEALTH ASSOCIATION HAVE BUILT OVER THE LAST THIRTEEN YEARS.

YOU ARE EMPOWERED, INDEED !

LAST YEARS SENATE APPROPRIATION LABOR, HEALTH AND HUMAN SERVICES SUB-COMMITTEE REPORT WAS CALLED " THE RURAL CHRISTMAS TREE ".

AND YOU HAVE CONSISTENTLY SCORED WELL FOR RURAL HEALTH INTERESTS IN THE PAST THREE BUDGET RECONCILIATION BILLS.

YOU HAVE INFLUENCED THE ESTABLISHMENT OF A FEDERAL OFFICE OF RURAL HEALTH POLICY AND ARE FORTUNATE TO NOW HAVE JEFF HUMAN AS A STRONG VOICE FOR RURAL HEALTH INSIDE THE BUREAUCRACY.

WITH EMPOWERMENT COMES THE STEWARDSHIP AND ALL THE RESPONSIBILITIES THAT GO WITH IT.

HOW CAN YOU BEST SERVE RURAL AMERICA ?

SO OFTEN MATURE MOVEMENTS PERPETUATE SELF SERVING POLICIES AND FORGET THAT IT IS NOT THEMSELVES BUT A CONSTITUENCY THAT MUST BE SERVED.

CLEARLY YOU HAVE DONE A GREAT DEAL TO FOCUS ATTENTION ON THE HEALTH NEEDS OF THE RURAL POPULATION.

YOUR CONTINUING LEADERSHIP TASK IS TO FORMULATE AND REFORMULATE A COLLECTIVE VISION FOR THE HEALTH OF RURAL AMERICA.

MY ASSIGNMENT FOR TODAY IS TO THINK ALOUD WHAT THAT VISION LOOKS LIKE FOR THE 1990'S.

IN THINKING ABOUT THIS ~~SPEECH~~ ADDRESS I WONDERED, WHAT CAN I CONTRIBUTE ?

I WAS BORN AND GREW UP IN ~~NEW YORK CITY~~ BROOKLYN AND LIVED MOST OF MY ADULT LIFE IN URBAN PHILADELPHIA.

AS YOU KNOW, HOWEVER, RURAL IS A STATE OF MIND AND BESIDES MY HEART WAS ALWAYS IN RURAL ~~HEALTH~~ NEW HAMPSHIRE. AMERICAS' SOUL HAS DEEP RURAL ROOTS.

LIKE JEFFERSONS' DREAM OF A NATION OF SMALL FARMERS, AND THE LURE OF THE 1/4 SECTION OF LAND (160 ACRES) THAT BROUGHT OUR LANDLESS PEASANT ANCESTORS FROM EUROPE,

OR THE DREAM OF "40 ACRES AND A MULE " THAT ENTICED SLAVES RECENTLY FREED TO HOMESTEAD AFTER THE CIVIL WAR,

RURAL AMERICA PROVIDES THE BREAD FOR OUR TABLES, THE FUEL FOR OUR CARS, AND THE WOOD FOR OUR HOMES, AND INCREASINGLY, THE SMALL MANUFACTURED PARTS THAT MAKE MOST THINGS GO.

PERHAPS THE MOST IMPORTANT CONTRIBUTION OF RURAL AMERICA, HOWEVER, IS ITS VALUES OF RESPECT FOR OUR PRECIOUS FARMLAND, AND AN UNQUESTIONED BELIEF IN THE FUTURE.

THE AMERICAN DREAM AND THESE HEADY, SOMEWHAT ROMANTIC THOUGHTS DON'T SQUARE WITH MUCH OF WHAT I SEE AS THE REALITY OF MODERN RURAL AMERICA.

BUT THERE IS NO DOUBT THAT THESE THOUGHTS DO BIND TOGETHER THOSE WHO COULD HELP CHANGE IT FOR THE BETTER.

I WILL FIRST PREACH TO THE CHOIR AND OUTLINE WHAT I BELIEVE ARE SOME MAJOR RURAL ISSUES, SOME IMMEDIATE ACTION STEPS THAT COULD BE TAKEN.

AND THEN CONCLUDE WITH SOME BROADER VISIONS OF DESIRABLE CHANGE.

A MAJOR ISSUE AND THE DRIVING FORCE BEHIND THE CURRENT SUPPORT FOR RURAL HEALTH IS THE THREAT TO THE CONTINUED EXISTENCE OF SMALL RURAL HOSPITALS.

THE CLOSURE OF A RURAL HOSPITAL MARKS MORE THAN A LOSS OF HEALTH CARE CAPACITY FOR THE COMMUNITY.

AS A MAJOR ECONOMIC PILLAR IT OFTEN TOLLS THE DEATH KNELL OF A [redacted] COMMUNITY.

BUT DATA ON HOSPITAL CLOSURES ARE LIKE MORTALITY STATISTICS, THEY REFLECT DEATH ONLY, NOT SICKNESS AND SUFFERING.

MANY RURAL HOSPITALS ARE BEING STRANGLED.

THIS MAY RESULT, NOT IN THEIR DEATH, BUT IN THEIR RELATIVE FINANCIAL AND ORGANIZATIONAL SICKNESS.

DHHS SHOULD MOVE ON ~~THEIR~~ ITS PLAN TO ELIMINATE THE URBAN/RURAL DIFFERENTIAL IN STANDARDIZED MEDICARE HOSPITAL PAYMENTS AS SOON AS POSSIBLE. MANY RURAL HOSPITALS WILL NOT MAKE IT UNTIL 1995 WHEN THE CURRENT PLAN IS TO GO INTO EFFECT.

I SEE NO REASON WHY THIS COULD NOT BE ACCOMPLISHED IN FY 91.

CONCURRENTLY DHHS SHOULD REFINE THE AREA WAGE INDEX UNDER MEDICARE TO REFLECT THE REALITY OF A SINGLE NATIONAL MARKET FOR HEALTH PROFESSIONALS.

I CONTINUE TO HEAR STORIES OF AGED VETERANS WHO MUST TRAVEL A HUNDRED MILES TO A VETERANS ADMINISTRATION HOSPITAL AND EVEN THEN MAY NOT BE SEEN THAT DAY.

LETS HELP THE VETERAN, DECREASE THE OVER-CROWDING OF V.A. HOSPITALS, AND INCREASE UTILIZATION OF RURAL HOSPITALS BY ALLOWING OUR RURAL VETERANS TO RECEIVE THE CARE THEY ARE ELIGIBLE FOR AT THEIR LOCAL HOSPITAL.

ONE OF

FARMING IS OUR NATION'S MOST DANGEROUS OCCUPATIONS, AND

ALTHOUGH ARE

FARM ACCIDENTS [redacted] A MAJOR PROBLEM [redacted] UNDER – REPORTED.

GOOD FARM SAFETY PROGRAMS COULD DECREASE NEEDLESS SUFFERING AND THE NEED FOR COSTLY MEDICAL CARE.

THERE ARE MANY NEW INITIATIVES UNDERWAY.

BUT I AM ESPECIALLY EXCITED ABOUT THE UNIVERSITY OF NORTH DAKOTAS' RURAL RESEARCH CENTER.

THERE THEY ARE DEVELOPING GUIDANCE IN ORDERING ROLL BARS FOR TRACTORS AND FOR ADAPTING ROLL BARS FOR DISCONTINUED TRACTOR MODELS.

THIS COULD PROVIDE A SOLUTION TO A MAJOR SOURCE OF FARM ACCIDENTS.

FARM SAFETY IS ALSO AN AREA WHERE THE EXTENSION SERVICE OF USDA COULD BE OF TREMENDOUS ASSISTANCE.

I ENCOURAGE DHHS AND USDA TO WORK CLOSELY TOGETHER IN THE AREA OF FARM SAFETY.

MENTAL HEALTH CARE SERVICES IN THE UNITED STATES ARE IN A SAD STATE OF AFFAIRS.

THE MENTAL HEALTH BLOCK GRANT PROGRAM, WITH ITS UNDER – FUNDING, IS A FAILURE.

MOST STATES HAVE ONLY SUFFICIENT RESOURCES TO TREAT THE CHRONICALLY MENTALLY ILL.

COMMUNITY MENTAL HEALTH CENTERS HAVE ABANDONED OUTREACH AND COMMUNITY ~~EDUC~~ PREVENTION PROGRAMS.

THEY LOOK INSTEAD TO MEDICAID AND PRIVATE INSURANCE TO COVER PATIENTS AND INSURE SURVIVAL.

LET ME REMIND YOU THAT MOST MENTAL DISORDERS ARE TREATED BY FAMILY PHYSICIANS AND THE CLERGY.

WE MUST RECOGNIZE THE INTERDEPENENT RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH AND FIND WAYS TO BRING THE TWO TOGETHER.

IN THE LATE 1970'S THERE WAS AN INNOVATIVE PROGRAM BETWEEN COMMUNITY HEALTH CENTERS AND COMMUNITY MENTAL HEALTH CENTERS CALLED "MENTAL HEALTH LINKAGES".

MENTAL HEALTH LINKAGE WORKERS, USUALLY SOCIAL WORKERS, CARRIED A CLIENT CASE LOAD, ACTED AS A LIASON, AND EDUCATED AND SENSITIZED THOSE PROVIDING PHYSICAL HEALTH-CARE.

THE PROGRAM WAS AS SUCCESS, BUT FELL TO THE BUDGET CUTS OF THE EARLY 1980'S. ~~ENCOURAGE~~ ITS REDISCOVERY WOULD BE OF CONSIDERABLE BENEFIT.

ON A MORE POSITIVE NOTE I APPLAUD THE RECENT ESTABLISHMENT OF A RURAL MENTAL HEALTH RESEARCH PROGRAM AT THE NATIONAL INSTITUTE OF MENTAL HEALTH UNDER DR. DELORES PARRONE.

I HOPE THEY WILL FUND RESEARCH AND DEMONSTRATION PROJECTS THAT UTILIZE THE RESOURCES OF PRIMARY CARE PHYSICIANS AND CLERGY TO HELP THOSE WITH MENTAL HEALTH PROBLEMS.

WE NEED MORE RESEARCH, BUT WE ALSO NEED PROGRAMS THAT WILL ADDRESS UNMET LOCAL NEEDS FOR INTEGRATED MENTAL HEALTH SERVICES.

THERE ARE MAJOR SHORTAGES OF HEALTH PROFESSIONALS IN THE RURAL AREAS.

WHILE I ADVOCATE RURAL HEALTH SYSTEMS THAT UTILIZE RELATIVELY SMALL NUMBERS OF PHYSICIANS; THERE MUST BE PHYSICIANS AVAILABLE TO SERVE IN RURAL AMERICA.

WE MUST MAKE RURAL PRACTICE ATTRACTIVE TO THEM AND TO OTHER HEALTH PROFESSIONALS.

I FAVOR REAUTHORIZATION OF THE NHSC, BUT WITH SOME MAJOR CHANGES. SCHOLARSHIP FUNDING PREFERENCE SHOULD GO TO MEDICAL SCHOOLS, LIKE THE KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE, WITH A LONG TRACK RECORD OF PRODUCING RURAL FAMILY PHYSICIANS.

WE DON'T NEED MORE EXPENSIVE URBAN ORIENTED PROGRAMS LIKE GEORGETOWN AND GEORGE WASHINGTON UNIVERSITY WITH EXPECTATIONS THAT THEY WILL PROVIDE RURAL PHYSICIANS.

PAYBACK

WE SHOULD SUPPORT DEFERMENT FOR PRIMARY CARE PHYSICIAN RESIDENCIES ONLY IN AHEC OR AHEC-TYPE MULTI DISCIPLINARY PROGRAMS PHYSICALLY LOCATED IN RURAL AREAS.

I SPENT SEVERAL HOURS WITH SEVEN YOUNG MEN AND WOMEN - LEAVING THE FAMILY PRACTICE RESIDENCY TO PRACTICE IN RURAL KENTUCKY. THEY ARE IN A PROGRAM THAT FORGIVES MEDICAL SCHOOL INDEBTEDNESS IN RETURN FOR A RURAL COMMITMENT. THEIR CALIBRE, THEIR DEDICATION WAS MOST ENCOURAGING - SUCH PROGRAMS COULD BE EXPANDED AND REPLICATED.

RURAL PRACTICE IS DIFFERENT.

WE DON'T NEED HUGE NUMBERS OF RURAL FAMILY PHYSICIANS AND WE DON'T NEED TO SPEND A LOT OF MONEY IF WE SPEND IT IN THE RIGHT PLACES.

THE N.H.S.C .SHOULD NOT BE A PHYSICIAN – ONLY ACTIVITY.

WE HAVE JUST AS GREAT A NEED FOR NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, NURSES, AND ALLIED HEALTH PERSONNEL.

ALSO

WE SHOULD ENCOURAGE STATES TO LICENSE MORE INDEPENDENT NURSE PRACTITIONERS FOR RURAL

AREAS. I WOULD ALSO ENCOURAGE MORE FLEXIBILITY IN NHSC ASSIGNMENTS TO ALLOW FOR EXPERIMENTATION IN NEW MODELS OF CARE. (E.G. ALLOW COMMUTING, ALLOW COMBINATION CHC HEALTH DEPT./ PRIVATE COMBINATIONS.

I WOULD LIKE TO SEE STRONGER STATE ROLES IN ESTABLISHING HEALTH MANPOWER SHORTAGE AREAS THAT ARE MEDICAL SERVICE AREA BASED RATHER THAN COUNTY BASED.

STATES SHOULD BE GIVEN AN OPPORTUNITY TO SET THEIR OWN PRIORITIES, WITH APPROPRIATE SAFEGUARDS FOR COMMUNITY HEALTH CENTER'S / COMMUNITY MENTAL HEALTH CENTER'S.

WOULDN'T IT BE GOOD

~~I WOULD LIKE~~ TO SEE STATE OFFICES OF RURAL HEALTH AS A MECHANISM FOR THIS AND ~~HOPE THEY WILL~~ EXPECT THEM TO TAKE THE BROAD APPROACH OF WORKING WITH PRIVATE AND PUBLIC PROVIDERS SUCH AS ~~LIKE~~ JIM BERNSTEIN HAS PIONEERED IN NORTH CAROLINA FOR ALMOST 20 YEARS.

I REFERRED EARLIER TO THE "RURAL CHRISTMAS TREE" IN THE SENATE APPROPRIATIONS REPORT.

IT CONTAINED SOME VERY ENCOURAGING THINGS : EQUITABLE FUNDING ALLOCATION TO RURAL / URBAN COMMUNITY HEALTH CENTERS, RURAL MENTAL HEALTH RESEARCH, INCLUDING RESEARCH & DEVELOPMENT AREA CENTERS, TWO ADDITIONAL RURAL HEALTH RESEARCH CENTERS (ONE MINORITY), ACADEMIC / PRACTITIONER LINKAGE GRANTS, AND A COMPREHENSIVE RURAL POLICY RESEARCH STUDY.

I CONTINUE TO WORRY ABOUT "SPECIAL POPULATIONS" : BLACK, HISPANIC, ELDERLY, ETC. AS COMMUNITY HEALTH CENTER'S / COMMUNITY MENTAL HEALTH CENTER'S, HEALTH DEPARTMENTS HAVE CUT BACK OUTREACH, THESE ARE FORGOTTEN PEOPLE,

I HOPE THERE ARE RESEARCHERS IN THIS AUDIENCE WHO WILL GO OUT AND SURVEY THESE POPULATIONS,

SO WE CAN RE - INVENT OUTREACH WORKERS AND COMMUNITY CASE WORKERS.

THESE SPECIAL POPULATIONS ARE DIVERSE AND WILL REQUIRE NEW APPROACHES SUCH AS WORKING THROUGH THE BLACK OLDER CHURCHES, AS WELL AS METHODS TRIED AND TRUE.

ALSO IN THAT REPORT WAS THE REQUIREMENT FOR SOME PILOT PLANNING GRANTS TO COALITIONS OF STATE HEALTH DEPARTMENTS, STATE PRIMARY CARE ORGANIZATIONS, AND UNIVERSITIES TO DEVELOPE STATE MIGRANT HEALTH AND SOCIAL SERVICES PLANS.

THE MIGRANTS ARE TRULY "THE WORKING POOR".

THEY DO SO MUCH; THEY ASK FOR SO LITTLE,

JUST A SHOT AT THAT AMERICAN DREAM I MENTIONED EARLIER.

MIGRANTS HAVE NO POLITICAL POWER.

THEY CAN'T TAKE PART IN OUR " INTEREST GROUP" STYLE OF POLITICS.

AT THE MOMENT THEY HAVE ONLY A FEW STRONG ADVOCATES LIKE SONIA REIG, DIRECTOR OF THE FEDERAL MIGRANT HEALTH PROGRAM, AND THERE MUST BE MORE.

HUMAN COMPASSION ASIDE, WE MUST REALIZE THAT WE ARE BECOMING PART OF A WORLD ECONOMY AND FOR MODERN AGRICULTURE TO SURVIVE AND COMPETE WE NEED A HEALTHY AND PRODUCTIVE MIGRANT AGRICULTURAL WORK FORCE.

I URGE STATE HEALTH DEPARTMENTS, STATE ECONOMIC DEVELOPMENT BOARDS, CONCERNED STATE AND FEDERAL AGENCIES, STATE PRIMARY CARE ORGANIZATIONS AND THE PRIVATE SECTOR TO COME TOGETHER AND SUPPORT THE DEVELOPMENT OF A SYSTEM OF AGRICULTURAL LABOR WE CAN BE PROUD OF; " HEALTHY HARVESTERS ".

AS A PEDIATRIC SURGEON, CARE OF CHILDREN HAS BEEN ~~MOST OF~~ PROFESSIONAL MY CAREER.

I WORRY ABOUT THEM AT ALL LEVELS AND AM ESPECIALLY CONCERNED ABOUT THE FIVE MILLION WHO LIVE IN POVERTY.

I HAVE A CONCERN THAT WE MAKE OUR SYSTEM WORK IN SUCH A WAY THAT CHILDREN RECEIVE THEIR BASIC NEEDS IN THEIR OWN COMMUNITY, BUT WHEN NEEDED, THE KNOWLEDGE AND SYSTEM MUST EXIST TO SEE THAT THOSE WHO NEED IT FIND THEIR WAY TO SPECIALIZED PEDIATRIC CARE.

AND FOR THE PAST SIX YEARS HAVE WORKED TO ESTABLISH THE PRINCIPLE OF COMPREHENSIVE, FAMILY CENTERED, COMMUNITY BASED CARE FOR SPECIAL NEEDS CHILDREN

I AM EQUALLY CONCERNED ABOUT HOW FAMILY PHYSICIANS CAN ACQUIRE THE ~~CONTINUING~~ BURGEONING KNOWLEDGE THEY NEED TO OPERATE IN TODAYS ENVIRONMENT.

I KNOW THIS ANSWER IS NOT JUST OUR LEARNED JOURNALS. I THINK IT IS PROBABLY SOME SORT OF INTERDISCIPLINARY HEALTH EDUCATION PROGRAM RELYING HEAVILY ON AUDIO & VIDEO TECHNOLOGY.

I ENCOURAGE THE AGENCY FOR HEALTH SERVICES RESEARCH AND POLICY TO DO THE NECESSARY RESEARCH TO DEVELOP THE KNOWLEDGE BASE FOR PROGRAMS TO MEET THE SPECIAL INFORMATION AND CONTINUING LEARNING NEEDS OF RURAL FAMILY PHYSICIANS.

THERE IS A GROWING CONCERN ABOUT THE SPREAD OF AIDS AND SUBSTANCE ABUSE IN RURAL AREAS.

DR. JUNE OSBORNE, CHAIR PERSON OF THE NATIONAL AIDS COMMISSION, SHARES THIS CONCERN AND HAS HELD HEARINGS IN RURAL GEORGIA.

I CAN'T PREDICT THE SPREAD OF AIDS IN THE RURAL AREAS, BUT I KNOW WITH CERTAINTY THAT THE FRAGILE RURAL HEALTH CARE SYSTEM HAS ALMOST NO TOLERANCE FOR ADDITIONAL PATIENTS.

HOW MANY CASES OF AIDS WILL IT TAKE TO BANKRUPT A MARGINAL SMALL RURAL HOSPITAL ?

THE ANSWERS LIE IN AIDS AND SUBSTANCE ABUSE PREVENTION EFFORTS, MORE DRUG TREATMENT SLOTS, AND SYSTEMS BUILDING FOR HEALTH AND HUMAN SERVICES LIKE THOSE SPONSORED BY HRSA'S PLANNING GRANTS FOR LOW PREVALENCE HIV STATES AND COMMUNITIES.

I CAN'T LEAVE WITHOUT MENTIONING THE ADDICTIVE AND DEADLY SCOURGE OF TOBACCO.

WE HAVE TURNED THE TIDE, BUT THERE ARE STILL AREAS OF CONCERN: TEENAGE GIRLS IN GENERAL, RURAL MALE ADOLESCENTS AND SMOKELESS PRODUCTS. SMOKING IS ~~[illegible]~~ MORE PREVALENT IN RURAL THAN IN URBAN AMERICA. THE HIGHEST COUNTY RATE OF EMPHYSEMA IS IN WEST. VA.

THE STRUGGLE GOES ON, AS THE CIGARETTE COMPANIES TARGET THE MOST VULNERABLE. THEY HAVE STEPPED UP THEIR ADVERTISING. INSTEAD OF THE 4000 THEY WERE SPENDING EACH MINUTE (2.5 BILLION/YR). THEY ~~[illegible]~~ ARE SPENDING 20% MORE THIS YEAR.

THESE ARE PUBLIC HEALTH ISSUES ALL OF US HAVE TO BELIEVE IN.

STROMER

THERE MUST BE A NEW COMMITMENT TO PUBLIC HEALTH.

THE HEALTH SYSTEM WILL COLLAPSE IF WE DO NOT SUPPORT DISEASE PREVENTION AND HEALTH PROMOTION.

I WOULD LIKE TO SEE A REVITALIZATION OF THE LOCAL HEALTH DEPARTMENT, PERHAPS IN THE KIND OF FLEXIBLE AND COOPERATIVE MODEL I PROPOSED FOR THE NHSC.

THE NEW LEADERSHIP IN HRSA (DR. BOB HARMON) COULD BRING THAT BACK AND REVITALIZE THE MORALE OF FEDERAL EMPLOYEES AS WELL. WE NEED NEW DIRECTION AND POSITIVE PROGRAM ACTION. I HAVENT SEEN OR HEARD OF IT YET.

IN MY VISION FOR THE 1990'S WE MUST ALSO HAVE SYSTEMS OF HEALTH CARE THAT MEET NEEDS WITHIN THE CONSTRAINTS OF EXISTING RESOURCES.

CONCURRENTLY THEIR MUST BE BETTER EDUCATION SYSTEMS, ECONOMIC DEVELOPMENT, AND SUPPORTING INFRASTRUCTURE.

THESE ELEMENTS ARE INTERDEPENDENT AND THEIR LACK CONTRIBUTES TO A CONTINUING CYCLE OF POVERTY. BUT THERE IS HOPE.

KENTUCKY'S RECENT DECISION FOR STATE – WIDE EQUAL FUNDING FOR EDUCATION IS A STEP IN THE RIGHT DIRECTION.

LONG TERM CARE FACILITIES DEVELOPED IN RURAL AREAS MEAN MORE JOBS AND DOLLARS FLOWING TO THE COMMUNITY.

THAT'S ECONOMIC DEVELOPMENT COUPLED WITH HEALTH CARE.

PERHAPS STATES SHOULD GIVE PREFERENCE TO CERTIFICATES OF NEED FOR LONG TERM CARE BEDS IN RURAL AREAS ~~OF~~ AS ONE WAY TO MEET THESE PROBLEMS.

ALSO, OUR MODELS OF CARE MUST START WITH REALISTIC NEEDS ASSESSMENT THAT RECOGNIZES THE UNIQUENESS OF EACH RURAL COMMUNITY.

AND THERE MUST BE A PLANNING PROCESS THAT INVOLVES AND EMPOWERS ALL OF THE COMMUNITY.

SUCH A PLAN MUST MAKE PROVISION FOR AT LEAST THE FOLLOWING:

* MECHANISMS FOR COORDINATION BETWEEN HEALTH AND SOCIAL SERVICES INSTITUTIONS.
* TRAINING OF COMMUNITY PEOPLE FOR EXPANDED AND PARAPROFESSIONAL HEALTH ROLES.
* OFF - SITE PHYSICIAN SUPERVISION & GREATER USE OF NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, MID - LEVEL MENTAL HEALTH WORKERS, MULTI - COMPETENT TECHNICIANS
* GREATER USE OF LOW COST TECHNOLOGY (E.G. FAX MACHINES, P.C.'S)
* REGIONAL AND STATE - WIDE SYSTEMS OF COMMUNICATION, REFERRAL, AND CARE.

MY TELEVISION STOOPING [illegible]
THE BASIC HEALTH CARE PROBLEMS ARE NOT MUCH DIFFERENT IN URBAN GHETTOS THAN IN RURAL AMERICA.

WE'VE ALWAYS SAID WE NEVER WANTED EVEN A <u>TWO</u>-TIER SYSTEM.

OF HEALTH CARE IN AMERICA.

BUT WE HAVE IT ... AND A <u>THIRD</u> TIER, ALSO.

IN THE FIRST TIER ... THE BOTTOM TIER ... ARE UPWARDS OF PERHAPS 30 MILLION AMERICANS -- ABOUT 13 PERCENT OF THE POPULATION -- WHO FALL THROUGH THE CRACKS AND HAVE NO HEALTH INSURANCE COVERAGE ... NO HIGH OPTIONS ... NO LOW OPTIONS ... NO OPTIONS AT ALL.

THEY'RE NOT OLD ENOUGH FOR MEDICARE AND NOT POOR ENOUGH FOR MEDICAID.

RECENTLY RELEASED FIGURES INDICATE THAT ONE OUT OF EVERY EIGHT AMERICANS FALLS INTO THIS CATEGORY OF THE UNINSURED. FOR BLACKS, THE FIGURES ARE WORSE, WITH ONE OUT OF FIVE BLACKS UNINSURED. AND IN THE HISPANIC POPULATION, ONE OUT OF EVERY FOUR PERSONS HAS NO HEALTH INSURANCE

WHAT, THEN, DOES THIS "HEALTH CARE SYSTEM" OF OURS DO FOR THE UNINSURED?

AS YOU KNOW, IN THE VAST MAJORITY OF CASES THE ANSWER IS ... VERY LITTLE ... OR NOTHING. AND THEY ARE SUFFERING THE CONSEQUENCES.

STUDY AFTER STUDY INDICATES THE CORRELATION BETWEEN NO MEDICAL INSURANCE AND INCREASING HEALTH PROBLEMS.

THE HEALTH PROBLEMS OF THE LOWEST TIER, IF IGNORED BY SOCIETY NOW, WILL BE BORNE BY SOCIETY LATER.

THEN WE HAVE A SECOND TIER.

THIS TIER RECEIVES A NARROW RANGE OF BASIC MEDICAL AND HEALTH SERVICES WITH MORE OR LESS FIXED LEVELS OF REIMBURSEMENT.

THIS IS LOW-OPTION COVERAGE ... MEDICARE AND MEDICAID COVERAGE ... WITH THE PATIENT PAYING MANY COSTS OUT-OF-POCKET OR WITH THE HELP OF SOME FORM OF SUPPLEMENTAL INSURANCE, WHICH IS -- IN MY BOOK -- JUST ANOTHER KIND OF OUT-OF-POCKET EXPENSE.

FINALLY, WE HAVE THE THIRD TIER, THE TOP TIER.

THE PEOPLE IN THIS TIER RECEIVE A FULL RANGE OF MEDICAL AND HEALTH SERVICES. THEY ARE COVERED BY HIGH-OPTION HEALTH INSURANCE AND ALSO HAVE A FEW DOLLARS LEFT OVER TO PAY THE 15 OR 20 PERCENT DIFFERENCE BETWEEN THE ACTUAL BILL FROM THE DOCTOR AND THE CHECK FROM THE INSURANCE COMPANY.

FOR THOSE WITHOUT ACCESS, THE GOAL IS UNIVERSAL COVERAGE TO BE ACHIEVED THROUGH COMPREHENSIVE REFORMS OF GOVERNMENT PROGRAMS FOR THE POOR AND UNINSURED COMBINED WITH RISK POOLING.

MEANWHILE INTERIM STEPS INCLUDE MEDICAID EXPANSION, UNDER EXISTING LAW, AND TAX INCENTIVES TO ENCOURAGE SMALL BUSINESS INSURANCE COVERAGE. ~~THESE LATTER ELEMENTS ARE THE ONLY ONES THAT REQUIRE PUBLIC POLICY REFORMS.~~ WE NEED SOME INNOVATIVE REFORMS ESPECIALLY DESIGNED FOR RURAL AMERICA

THE TIME IS RIGHT FOR CHANGE AND THE ELEMENTS EXIST:

– A MATURING RURAL HEALTH MOVEMENT

– A HEIGHTENED CONGRESSIONAL INTEREST

– STRENGTHENED STATE HEALTH DEPARTMENTS

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- STABLE COMMUNITY AND MIGRANT HEALTH CENTERS

- GROWING NUMBERS OF STATE OFFICES OF PRIMARY CARE

-COMMUNITY MOBILIZATION AROUND POTENTIAL RURAL HOSPITAL CLOSINGS

THE TIME IS NOW AND YOU HOLD THE KEYS •

IN CLOSING, I PLAN TO SPEND THE CURRENT PHASE OF MY CAREER MAKING AMERICA AWARE OF ITS HEALTH PROBLEMS SUGGESTING APPROACHES TO CONFRONTING THEM, AND GOADING THE COUNTRY TO ACTION. YOUR GOALS ARE SIMILAR.

I WILL NEVER BE A "COUNTRY BOY", BUT I WILL SUPPORT THE EFFORTS OF MY "COUNTRY COUSINS"S IN THE NRHA AND BE PROUD TO BE THEIR FRIEND.